INTRODUCTION

BURNS : A PSYCHOSOCIAL PERSPECTIVE

A Theoretical frame of reference based on Review of Literature:

The gravity of the problem of Burns has been well established. Burns, rightly described (Merchant:1981:5) as "Thirty seconds of terror and a regret of life time" has caused concern to various disciplines engaged in human welfare. The complex etiology, the terrifying episode and the consequent mortality or the physical, economical, psychological and social morbidity invite a multi-professional attention to the problem. The management of the medical aspects in terms of immediate care, long term indoor treatment, physiotherapy and plastic surgery, in itself, is a mammoth task. The limited resources of trained manpower and the lack of appropriate service infrastructure required for proper care intensify the problem.

The medico-legal aspect of Burns stands out with its stigma of long, tedious police routines and punitive judiciary issues. The illness not only interrupts the ordinary pattern of living but affects the person's attitude about himself too (Field:1953:15-17). The emotional problems and psychiatric morbidity require long term attention. The social significance of the problem

of Burns probably claims highest attention because of various reasons. The dynamics of behaviour of the patients "who are also people" and "persons-in-their situation" (Gestalt theory) is linked up with both etiology, the reception of treatment and the rehabilitation issues. The problem of Burns strikes both the developing and the developed countries. The variation may be seen in terms of the causes and the treatment, but the severity of the problem and the need for multi-professional attention has been internationally accepted.

THE MAGNITUDE OF THE PROBLEM

The seriousness of the problem of Burns in terms of mortality and morbidity is well established. Availability of the accurate data is however difficult. The W.H.O. (Park and Park,1969:416) estimates a high incidence of Burns in various countries of the world. Twenty percent of the cases are fatal while majority face severe physical and psycho-social morbidities. A researcher from America (Emillie Black, 1981:89) reports that "Of the 300,000 people in U.S.A. who receive Burns severe enough to cause disability, 30,000 require prolonged intensive care. Despite this excellent care, thirty eight percent die. It is evident that the management of severe burns is still a critical problem in U.S.A.". Mohammed (1981:24) in his

study on burn injuries in Bangladesh reveals that women and children under five are main victims.

A recent study (Chaurasia: 1981) reports that "Mortality from Burns in selected countries of Africa and Asia has been on relative decline. However, the risk of death for females is increasing as compared to males. In some countries, it is more than double to that of males. The least mortality was found in age group of 5-14 years while 0-4 age group stood out as high mortality risk group in the countries under review".

The condition in India is more shocking. Approximately "Six to eight lakh people suffer Burns in India every year, about one lakh of them die. Bombay takes the toll of approximately one thousand persons through Burns" (Keswani, 1980:1). Civil Hospital, Ahmedabad reported an intake of 2011 patients in Burns wards during five years, every third case proved fatal (Shah, 1979:5). Out of 1200 cases reported of accidents, every fourth was due to Burns. Women and Children are at greater risk. Bombay Municipal Corporation data revealed that out of 565 children under 14 years in 1976, every four was due to Burns (Mahadevan, 1978:26). An epidemiological study (Pai, Kulkarni, 1987:14) reveals that females constitute approximately fifty eight

percent of the total cases of Burns, the mortality rate for females was more (thirtyone percent) while that for males was twelve percent. A.M.Learmonth (1980:139) reports on sixtynine case histories of children who suffered domestic Burns and scalds in Rajkot. A study (Kashalikar, 1981:23) from Miraj, Maharashtra speaks of two hundred cases where domestic Burns were in majority. The S.S.General Hospital, Baroda admitted 2541 cases in five years, every third case of these did not return home. The sexwise comparison to general population revealed that loss of life was more in women and children (Census, 1981).

SOCIAL ASPECTS

The concept of social functioning (Boehm, 1959:19), (Hollis, 1965:23) explains the necessity of viewing the overt behaviour of a person in the problem, from his infantile needs and his ego-superego functioning on one side and the environment on the other, represented by his socio-economic status, education, medicare and security he enjoys coupled with his values and ethnic bearings. The system theory views the personality as an open system in constant interplay with its surroundings receiving stimuli from environment and modifying its internal mechanism to maintain an equilibrium while adjusting to changes from without (Stream, 1978:27).

Medical social work literature has highlighted Burns as both the cause and the consequence of a social problem. A probe into the victims of Burns by various authors has highlighted factors that contribute to a "risk profile" of cases of Burns.

Studies conducted at the Faculty of Social Work, Shah J. (1963:53), Shah S. (1963:61), Satkalmi (1966:87), Trivedi (1968:70), Patel (1974:49), Shah (1979:53) have made an effort to provide the psycho-social profile of the respondents and to describe the conditions prevailing before and after the episode of Burns. No correlation has been established between causes and effect in view of the relatively smaller samples. Attention to the management aspects is however wanting in these studies.

Natu et al (1974:37) conducted a study (N-2000). The salient findings emphasized the various social, psychological and physical aspects.

Factors such as Age, Sex, Education, Income, Family Size, Housing conditions, Kitchen arrangements, Nature of Fuel, Style of cooking, Material and style of outfit have been established as important factors causing conditions conducive to Burns.

Survival and mortality studies in respect of percentage of Burns and period between accident and treatment, have emphasized the importance of proper and immediate management. Doshi et al (1981:15) studied 1200 cases highlighting the importance of factors that prevented people from being helped. Chowdhury (1981:24) in her paper 'A Lady's not for Burning' highlights the century old traditions of burning women under punitive, religious or fanatic privileges which still continue in a modified manner under the guise of dowry and similar traditions. Gupta (1981:29) reports occupational aspects as important variables. Black (1981:89) from U.S.A. suggests the need for multiprofessional approach in management of Burns for 300,000 cases in an year in U.S.A. who suffer the disabling effect of Burns.

Religio-Social Aspects:

The history of civilization evidences the burning of women under various pretexts such as religious fanaticism, socio-political traditions or testimony to the chastity of women, in other words, burning of women has been accepted with social sanction and glorification, throughout the human history.

Sir Macdonell (1931:57,51) in the account of the historical trial of Joanne D'Arc, who was subjected to humiliation in the market place at Rouen describes that she was made to wear a paper crown marked "Heretic,

Relapsed Idolator, Apostate", and was burnt in public. Her persecutors' last acts were to tear aside the faggots to show that she was, in truth a woman. The trial marks the period when women became the subject of social persecution.

The history of India also evidences the burning of women. Sita, who was required to walk through fire in order to prove her chastity, Madri who committed 'Sati' after King Pandu are the ancient examples.

The Jauhar committed by Rajput women to save their character and regal honour (surrender to fire, not to your enemy) during wars depicts the tradition (Mehta,1987:I) as nothing short of a collective suicide of socio-political origin.

The recent episode (September 4, 1987) of 'Sati' at Deorala, a village in Rajasthan is a slap in the face of development ! The episode seen from a socio-psychological angle depicts the status of women in India, though 'Sati' is abolished from most of the States in our country. Various factors (Mehta, 1987:I) that lead a widow to the flames of her husband's pyre include a psychological compulsion to attain 'Sat'. What is real, true, good or virtuous and is encouraged by social glorification. The life of widows, in upper caste Hindu society is based on

denials and sacrifices like abstinance from all that can make a life pleasant and a woman attractive and happy. Whether as a result of childhood conditioning, or role modelling of ideal women, pressures of customs and traditions or outright coercion; the women continue to be victims of unfair cultural traditions.

PSYCHOLOGICAL ASPECT

The insight into the human behaviour has changed with the development in understanding of dynamics of behaviour. The change witnesses a journey from "Demonology to the concept of positive mental health and from the dichotomy of the mind and body to the knowledge about the integrated personality" (Master, 1967:38). The facts that the psyche and the soma of an individual are inseparable and that a trouble psyche manifests in a disturbed soma and vice a versa are well established. The modern understanding of a human being as a 'person-in-his situation' requires a consideration of both his psychological and environmental conditions in understanding the problem.

The physicians come across patients using expressions like "that was a heart break", "could not stomach that" and a number of other cries for help. It is well known that "the undischarged quantities of anger can lead to migraine headache or insomnia,.. giving rise to other complications" (Strean, 1978:121). Another approach (Dunbar,

1947:101) relates the whole business of "accidentisis" to persons posing a special profile with impulsiveness, need for pain and living a life leading to tragedy". Upham (1953:50) explains that "Every illness has a psychological meaning to every patient and they react differently to illness and disability, finding in the experience varying degrees of frustration and pleasure".

Advent of social psychiatry furthered the understanding of motive of Burns - whether suicidal, homicidal or accidental in nature in terms of different personality types, strong aggressive impulses which could not be expressed outwardly (Farberow, Schneidman, 1965) or Menninger's analysis of impulse derived from 'wish to kill, to be killed or to die' or Bergley's explanation in terms of guilt or hysterical unconscious dramatization or the preoccupied accident prone personality types; the psychological stimulus is seen to be contributing to the resultant - the episode of Burns.

The studies on attempted suicides also refer to Burns as one of the modes adopted by the subject. Approximately, five to six percent of attempts of suicide had adopted burning as a mode. The report of the Saurashtra Suicide Inquiry Committee (Bhatt, 1957; Trivedi, 1968:105, Dave, 1977) endorses the same. Jyoti Sangh, a leading women's organization of Gujarat (Jyoti Sangh, 1986:3) reports thirteen

percent of their cases as suicides, five percent as homicides, most of the cases being of married women.

The most recent studies include those of Baarur (1981: 22) emphasizing consumer rights. Mary Knudson-Cooper of U.S.A. (1981:5) refers to development of a 'risk profile' of children. The author considers Age, Sex, S.E.S., Family Type, Family Stress and History of Behavioural Problems in children as important factors. Verghese (1981:9) explains the post accident condition of patients as depending on the location, extent and physical and psychological background of the patient. Kulkarni (1981:23) reports high mortality due to Burns and five percent of the same were attributed to suicides or homicides due to personality and/or environmental factors.

The Consequences of Burns : Social-Psychological:

The social consequences of Burns are grave. The stress of witnessing a traumatic episode of Burns, medico-legal implications and the untimely, sudden death of a loved one leads to crisis situations. "The upset in the steady state disturbs the equilibrium attained by adaptive manoeuvres fulfilling individual needs and the sudden discontinuity upsets the state of homeostasis, the family finds hard to regain" (Rapoport, 1970:276).

The problems for those who fortunately or unfortunately survive are even worse. The long hospitalization for treatment and plastic surgery result into disruption in occupational and familial roles resulting into the economic and social dependency. The physical disability and the deformities result into the social rejection especially in the case of married women. The doubts of attempted suicide evolve cumbersome legal complications compounding the social strains and rejection of the victim.

The emotional morbidity is probably the most severe disabling factor. The physical disfigurement and the shock of the episode leave deep scars on the psychological bearing of an individual. The fallen - self image, deflated ego - strength may contribute to fears and threats of rejection leading to distortion in perception and a whole chain of defence attempts to attain individual and social adjustments. The problem of Burns projects itself as a severe social problem in terms of loss of economic productivity and social dislocation.

Several authors have discussed the importance of the 'post-episode' phase in terms of envisaging the problems and the needs of the patients.

The coconut grove fire in Boston was the first major instance to draw the attention to the psychological

perspective of Burns. It was found (Cobb, Lindemann, 1943:117) that many of the victims of fire at that time suffered from persistent and serious emotional problems.

Granite and Goldman (1975:593) explain that for both the patient and the family, a severe Burn is an injury of catastrophic proportion. The circumstances of the accident and the injury itself pose difficult problems like grief reactions to losses in the fire, guilt feelings regarding the causes, regret over the inaction and the stress due to seperation owning to long hospitalization.

Hamburg et al (1953:253) describes the trauma showing that a severe burn is extremely painful and slow to heal followed by years of rehabilitation. The patient must endure daily treatment inducing pain and multiple corrective and cosmetic surgery. Deformities and loss of functions are realities that need to be accepted.

The psychiatric problems (Andreasen et al, 1974: 785-93) arising out of Burn include premorbid psychological disturbance among those who are prone to Burn injuries. The suggestions for post-burns interventions suggest (Andreasen, 1972:286) ameliorative and preventive interventions to be applied during the hospitalization. Observations on process of recovery highlight (Andreasen, 1972b:285:89) the adjustment to normal life. It was seen that whose who had functioned before Burns, as productive, well integrated persons, re-established faster.

The problems of the families, as seen in a study at the University of IOWA Hospitals and Clinics (Broadland, Andreasan, 1974:5) are equally severe. The relatives of the patients of Burns undergo many of the same stresses as do the patients.

MEDICO-LEGAL ASPECTS OF BURNS*:

The victim's general health is also seen as one of the contributing causes not only to the event of Burns but in terms of determining the severity of Burns or mortality (Mody's Jurisprudence 1965). Epilepsy, mental illness, physical disability and indication of anaemia etc. were some of the salient health factors leading to Burns.

The problem of Burns, its timely management and thorough follow-up forms an important area of the medical (clinical) management of burns. The nature of burns, the degree and percentage of Burns, the body areas affected and the timely management of Burns are the issues contributing to the prognosis of the patient. These issues are of great importance to the social worker who is a part of the professional team, in terms of preparing the family to survive the initial shock and assemble all the material and human resources to tide over the crisis. It is thus appropriate to have an overview of the medical and legal aspects of Burns.

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*It would be appropriate to mention at the outset that the core of the discussion concerns the issues related to the disciplines other than social work. A heavy dependence on review of literature of medico-legal base is inevitable. The word Burns has been shown in capitals to emphasise the issue.

MEDICAL ASPECTS:

Physical Health:

Mody's Jurisprudence (Mody, 1965) describes Burns as "injuries produced by the application of flame, radiant heat or some heated solid substance like metal or glass to the surface of the body. Injuries caused by friction, lightening, electricity, X-ray and chemical substances are all classified as Burns for medico-legal purposes".

Scalds are moist heat injuries produced by the application to the body, of a liquid at or near its boiling point or in its gaseous form such as steam. Scalds by liquid other than water are more severe as oil or molten metals boil at much higher temperatures than water and harm the tissues as they stick to the body. Burns by ionization, lightning, dry ice, gas jets have their distinct effect on the body important enough to be noted for legal purposes.

Classification of Burns:

According to the old British classification, Burns are classified in six degrees and according to the modern system, into three degrees. The latter classification covers both the depth as well as the consequences.

First Degree (New)

This covers the first and second degrees according to the old classification. The medical jurieprudence states

that (Jhala, Raju, 1981;367-370) "It is the result of simple inflammation with heat. The cutis or true skin is not involved. As a result there is no scar formation. If there is redness only (old 1st degree) it usually subsides in a few hours, with thick skin, as of palms and soles, may persist longer, the cuticle peels off and there is no residue of old injury. If there is blister (old IInd degree) it appears immediately. If, because of lifting of the cuticle, or if cuticle is removed, infection is likely. Because of infection, scar is inevitable.

Second Degree (3rd and 4th degrees of old classification)

This refers to destruction of both dermis and epidermis. This leaves a yellow or a brown patch. This is often surrounded by the inflammatory redness or blisters. The Burn looks shrivelled and puckered towards the eschar which is depressed within 4-6 days, the eschar falls off leaving an ulcerated cicatrix. This heals slowly leaving a scar or cicatrix. The depth of the burn, depending on the temperature responsible, and result of cicatrix viz. deformity or disability have important medico-legal bearings. It is the depth which governs the amount of scarring and the nature of tissue, and its extent, the type of scarring. The latter governs the obstructive phenomena

in various joint movements both by involvement of muscles participating as well as by restricting the movements in the form of bands".

Third Degree (5th and 6th degree of old classification)

In this type, all layers of skin, subcutaneous tissue muscles and even bones are involved. According to Jhala, et al, (1981:371), "This is due to the process of charring which involves the whole part. Question of possibility of scar does not merit consideration. In these Burns, the degree of shock and possibility of infection is so high that depth is more a rule than a chance exception. Of course, if only a very small area of skin is involved, not affecting vital vessels or plexuses of nerves, death may not ensue. All the same, invariable infection prolonged healing and bad scarring are inevitable".

Inspite of the fact that degree is the most important medical point in the medical notes of Burns, extent and situation are no less important.

Effect of Burns:

The effect of Burns (Mody, 1965) is "related to the degree of heat applied, duration of exposure, extent of surface, the site, the age and sex of the patient".

MEDICAL REASONS OF DEATH IN BURNS:

Shock: Shock to nervous system, feeble pulse, cold and moist skin followed by collapses result into death. In children, it may lead to stupor and insensibility to coma and death. If heart is weak or diseased, the fright may lead to death.

Suffocation: Persons removed from houses on fire are found dead by carbon dioxide or carbon monoxide produced in combustion.

Accidents/Injuries: Caused in attempt to escape from house on fire.

Inflammation: That of serous membranes of internal organs in cases of meningitis, oedima, pleurisy and perforation of ulcers. Hypoproteinaemia, marked fluid loss and anaemia. Exhaustion from suppurative discharges for very long durations. Lardaceous disease of the internal organs.

MENTAL HEALTH ASPECTS:

The predisposing factors of Burns relate to a variety of problems of mental health. Amongst them depression and Epilepsy show a closer relationship with Burns episodes. A wish to kill or to be killed, tensions that make the patient prone to accidents and those due to epileptic fits are some of the important precipitating factors for the episode of Burns.

Depression, an affective disorder is concisely defined (Mester, 1967:405) as "A symptom-complex, characterised by emotional dejection, and accompanied by other physical concomitants". The central symptoms of Depression (Mendels, 1970:6) can be summed up as "Sadness, pessimism, self-dislike, along with a loss of energy, motivation and concentration. The major issues in depression over and above those of mood, thought, behaviour and appearance, somatic symptoms and anxiety also include suicidal behaviour in terms of thoughts, threats and attempts at suicide".

Suicide is observed as an important cause for deaths throughout the world. According to Mendels (1970:12) "more than 20,000 people kill themselves each year in U.S.A., making suicide the eleventh most common cause of death. The suicide rate per 1,00,000 per year for depressed patients was 556. This is significantly higher than in other mental illnesses. Suicidal attempts are more common in women than in men, but deaths due to the same are more common in men. Suicide is more common in elderly persons (Batchlor, 1957:14) and is due to lack of meaningful involvement in social life. Reflections on suicide by Durkheim (1897:307) support this observation. Farberow and Schneidman (1965) observe suicide as a "Cry for Help".

The relationship between depression and suicide is well established. The use of Burns as the mode of committing suicide is only one of the ways in other countries. In India, especially in women, it is one of the common modes (Jhala, Raju, 1981:379) due to social deprivations and easy access to fire.

Epilepsy is yet another mental health problem associated with Burns. Lack of continuous treatment for arresting the disease leads to 'falling into fire' during work at the place of job, and in kitchen.

Emotional aspects hold important place in the recovery. According to Mehta (1981:10), "Burns is a very important problem in this part (Gujarat) of the country. It is more frequently accidental but often it is suicidal or even homicidal. In the latter two conditions, emotional factors played a very important role in the management and recovery of burnt persons ... anxiety, fearfulness, anger, depression regression and psychosis being some of the emotional responses".

Modern Management of Burns:

Forty years have passed since India became free from the British rule, but submission to traditions and the life-style incorporated during the period, still persist. First aid in Burns is one of the areas where the influence

of procedures advocated during British rule, still influence the minds of the people.

The faulty practices include covering of the body by a woollen blanket, rolling on floor and application of things like oil, ghee, butter, cream, ink and potatoes. These procedures, though soothing, permit and aid in retaining the heat inside the body. The heat so retained permeates to the deeper layers of the skin affecting epidermis, muscles and even bones. The outcome is a damage that results in contractures making plastic surgery inevitable for full recovery.

The modern concept (Kaswani, 1983:6) suggests that "It is extremely important that fire should be put out as rapidly as possible and that the skin should be cooled immediately. The best way to put out the fire is with water and the best first aid for Burns is cold water, the colder the better".

An Australian journal on Burns further explains the procedures: "The burnt area should be drenched in running cold water or preferably placed in a basin of cold water to which ice-cubes have been added. Where this is impractical as the case of Burns to the head and neck, shoulder, chest, abdominal wall or back, cold wet towels which are kept in a bucket of ice water are applied to the burnt area" (Agnivarta, 1983:13).

The present generation of adults (Gunay, Kesvani, 1983:3) were taught "to wrap a burnt person in a woollen blanket. It would be extremely difficult to teach them to pour water on Burns. Relearning of newer values, is always a longer and difficult process". Education of public in the correct ways of management of Burns is one of the areas for social work attention.

The foregoing discussion has presented the medical aspects of Burns indicating the importance of timely management of Burns. Here two major issues claim attention from the social perspective. The knowledge (or lack of it) about the appropriate ways of management and the intentional delay of the victim, or people surrounding the victim in immediate treatment of Burns. This has some relevance to the legal aspects of Burns. It would be appropriate to review the legal aspects before commenting on the social implications and social work intervention.

LEGAL ASPECTS:

The episode of Burns comprises of injuries of high medico-legal importance. Burns causing morbidity or death invite legal procedures which often prove cumbersome, irrespective of the episode being accidental, suicidal or homicidal. The target is not only the victim but also the relatives, close associates and the institutions employing the victim. The last is important if the victim is burnt

during working hours, due to the liabilities of compensation and insurance. The dying declaration is yet another area of legal importance.

"The sections 324 and 326 of Indian Penal Code refer to Burns as injury by means of fire, or any heated substance or any corrosive substance" (Jhala: 1981; 367).

Medical jurisprudence (Mody, 1965) reflects that "Burns would be justifiably grievous, if they cause scars causing permanent disfiguration of head or face, permanent loss of sight of either eye or permanent impairment of a member or a joint owing to the formation of cicatrix or contraction, if a joint or its neighbouring parts have been severely burnt".

Indian Penal code vide Section 324 states that "Burns are grievous if the individual has suffered from shock so as to endanger life or if he has been in severe bodily pain or bedridden and unable to follow his ordinary pursuits for twenty days. Section 324 and 326 of Indian Penal Code deal with "simple or grievous hurt caused voluntarily by means of fire or any heated substances, or any explosive substance".

The decision about whether an episode of Burns is accidental, suicidal or homicidal is difficult to make as the data usually is insufficient. The determinants of the nature of episode include the situation and accessibility,

site, extent and degree of Burns. Jhala, Raju (1981:376) highlight the differential diagnosis as follows: "A genuine accident has no limitation of site. In homicides, areas of skin affected offer valuable assistance. These often indicate possibility of obstructions (trying to prevent resistance or occluding or covering the face to prevent crying for help). Accessory factors like kerosene in the hair, point to likelihood of suicide. A majority of Burns, meaning eighty percent of deaths from Burns, specially suicidal, occur in females. Family dissatisfaction and uncalled for conceptions in virgins and widows contribute a common precipitating factor". Examination of uterus for products of conception in every case of the death of a female from Burns is necessary. Burns often may be followed in a homicide for covering the signs of strangulation or poisoning by charring the body. It is thus necessary that all cases of Burns should be thoroughly examined and investigated.

The immediate management of Burns usually starts with the general practitioner or a family physician. The easy accessibility in time and distance explain the situation. The physician, due to reasons, sometimes lack of facility of treatment and many times for fear of involvement in medico-legal formalities, refuses the cases and offers help in getting admission to the Government Hospital.

According to Jhala et al (1970:1-2) "Even though it is not mandatory to inform the police of the incidence, it is incumbent and obligatory for a doctor to assist and cooperate with the police. The moral and legal responsibility of a doctor makes it obligatory for him to do the following:

1. In all cases of Burns, where death is an imminent certainty or has high probability, to give information to the police is the duty of the doctor. So also is his legal and moral responsibility in the following types.

2. Incases of Burns where the 'nature' of Burns (episode) is doubtful.

3. In cases where death has already occurred and doctor is in know of the background of the case.

4. In cases of suspected Burns where a doubt of foul play cannot be ruled out.

5. In cases of Burns where no history or facts of cases are available.

In frank accidental cases (children), only serious cases are to be informed. Even in frank accidental deaths police has to be informed. This timely step facilitates issues in reference to compensation and insurance in cases of an adult death.

Dying declaration is yet another area of importance. It is based on the concept (Jhala, et al,1978:1) that "Truth sits on the lips of a dying man". Hence even law assigns confirmatory importance if the person making the declaration is no more. If the person survives, legally it has corroborative importance. In dying declaration the patient concerned has to be aware of the imminent death. It is only under such circumstances that the person morally withdraws from the world and states the truth. Maintenance of comprehensive records of all events, strengths and limitations of the case, is a requirement, useful to all concerned".

THE SOCIAL IMPLICATIONS:

The foregoing discussion, based on the review of two disciplines - medicine and law, clearly bring to notice the social implications of the problem in reference to the predisposing factors and the obstacles in timely medical-legal attention to Burns.

Inappropriate immediate management of Burns leads to chances of infections, mortality and disfigurement leading to persistent, perpetual, progressive agony resulting from social-emotional rejection of the victim. The factors contributing to the former conditions include ignorance of the correct ways of management resulting from

poor status of education due to poor socio-economic conditions. The lack of 3R's close the door to many written stimuli of socialization and modernization. The delay in timely access to medical treatment has the inclination (or lack of it) as one of the causes. The fear of involvement in procedures of interpretation of law (Judiciary) and those of the enforcement of law (Police) come as obstacles in exposing the victim to a proper medical agency. The clandestine treatment resorted to in some cases, leads to the patient being brought to general hospital when the case has deteriorated, due to infection. This is a result from ignorance and it refers again to the poor socio-economic status of the injured and the doctor is patronised by ill affording uneducated persons.

In other cases the factors of distance between hospital and home or lack of transport facilities result in wastage of time due to poor socio-economic status. The ignorance about importance of treatment of depression and continuous medication in epilepsy refer to lack of knowledge about ways and service infrastructure for the same.

The concept of social functioning (Hollis, 1972:16-20) and the concept of quality of life (Dreunouski, 1974) explain the situation as a result of various social,

psychological factors. Proper education to people in management of Burns is seen as an important aspect. The place and scope of social work intervention is obvious in management of Burns. This is bound to lead to fewer cases and better results. Thus this study would reveal that attention of socioeconomic problems and mass education could be rewarded by lasting benefits to the individual, potential victims of the society and above all the child/children rendered motherless by the catastrophe.

The foregoing discussion precipitates that -

- Poverty, illiteracy, large family size, poor housing and lack of civic amenities create conditions conducive to Burns.
- Lack of orientation to safer life styles through lack of knowledge about proper equipments and arrangements at home and work place rate as important causative factors.
- Pressures of social norms and traditions expressed in terms of demand for dowry, lower status of women in family system, lack of say in marriage matters contribute to conditions leading to Burns.
- Psychological stress due to conflict prone competitive, fast life-style, epilepsy and other illness, strong aggressive impulses and a desire to kill or to be killed are some of the psychological factors leading to Burns.

THE PROBLEM:

Burns is a serious problem in terms of magnitude and the consequences of physical and psychosocial morbidity and mortality irrespective of the episode being suicidal, homicidal or accidental in nature. The culture-born symptomatology, the pressures of social norms and traditions, the socio-economic status and the life style peculiar to a region explain the pattern of Burns for a specific region. It is thus, appropriate that a probe into the life-style of the cases of Burns precedes any attempt at the management and prevention of Burns.

Consequently, the problem of Burns projects itself as both the <u>cause</u> and the <u>consequence</u> of a psychosocial problem. The factors like socio-economic deprivations, poor inter-personal relationships, pressures of social norms and health anomalies are some, from the multiplicity of factors, that explain Burns as the cause of a psychosocial problem. On the other hand, disfiguration of body, rejection and self reproach, drain on economic and human resources and social stigma upset the 'socio-stasis', start a series of new psycho-social problem.

The problem of Burns (Bosuick, 1981) strikes both with the developing and the developed countries. The variation may be seen in terms of the causes and the treatment, but the severity of the problem and the need for multiprofessional attention has been internationally accepted.

THE PURPOSE:

The need for social work intervention in attending to the problem of Burns is required at all levels starting from the crisis-intervention at the time of admission, help in acceptance of sick-role and long term treatment resulting in total rehabilitation through the therapeutic intervention. The preventive aspects cover the utopean (!) tasks of change in the socio-economic status, service infrastructure and emancipation of women. The more feasible tasks include education of communities for adopting safer lifestyles, seeking timely help for physical-mental health problems and interpersonal conflicts. The education for proper management of Burns at the time of episode can contribute in improving the prognosis of the victims.

The usual, ultimate goal of social work research in most cases is the consumption for service to humanity. The service in reference to problem of Burns would seem as a mammoth task to anyone interested in human welfare. The I.C.A.C. Document appropriately narrates the feelings of the researcher.

"Faced with a problem, How do you know what to do? ... Many sick, few doctors, few hospitals, shortage of medicines, diseases spread without an end. In vain, Doctors struggle against them, after they have already taken their toll ...

A vicious circle remains unbroken, where consequences rather than causes are attempted, where help comes after the catastrophe has already struck. Where action follows criteria and models that do not correspond to local conditions... Faced with them, what do we do, if at all we do?"

Bent-Sorensen (1984:12) rightly quotes Kipling as "not before an answer to the where and how are known, can a campaign be initiated and... that an epidemiological mapping of the causes (and management) of Burns must precede if a rational preventive effort is to end successfully". Hence the study.

SIGNIFICANCE OF THE STUDY:

The world over, it has been accepted that Burns prevention and effective teaching of it, is the pivotal point around which a strong preventive programme can be evolved.

Hence the dominant theme should be to study in depth, the different facets of Burns ... In developing countries (Merchant, 1981:1), the great majority of Burns are suffered in the home and kitchen ... unless timely care is rendered, you cannot treat Burns for long without leaving physical and emotional scars..."

The W.H.O. (1979) and various other organisations emphasise on the social aspects of illness and the community education for the prevention of Burns. But the number of studies to understand the social factors that lead to Burns and especially the factors that block timely and proper health-care are very few. The study in reference can contribute in this area.

The problem under study falls within the scope of medical and psychiatric social work as well as family and women's welfare. The data can be useful to both social work practitioners as well as educators in understanding 'illness' both as a cause and consequence of psychosocial problem.

The first Afro-Asian Conference on Burns (1981) has emphasised on the education of people on adopting safer life styles and immediate management of Burns. The study can provide useful guidelines to plan such programmes leading to 'emergency centres' in the city.

The study makes no tall claims being on a smaller sample. It can, however, help in formulation of a hypothesis for a statewide study on Burns, as Gujarat is one of the states to claim priority in attention to Burns.

OBJECTIVES:

The major objectives of the study is to obtain an insight into the predisposing factors and the immediate management of Burns. The specific objectives of the study aim:

- To probe into the 'person-in-situation' of the respondents (socio-economic profile, life style and relationships of the respondents).
- To probe into the episode of Burns.
- To probe into the procedures of immediate management of Burns.

PROCEDURES OF THE STUDY:

RESEARCH DESIGN:

The study aims to gain familiarity with and, to an extent, portray accurately the characteristics of the phenomenon, of Burns and its immediate management (Selltiz et al, 1962:50). The design adopted is "explo-ratory-descriptive".

UNIVERSE AND SAMPLE:

The problem of Burns carries medico-legal implications and hence the cases are almost necessarily brought to a general hospital. The S.S.G. Hospital being the district hospital covers cases from the whole of Baroda district and

hence qualifies to be the universe. The epidemiological mapping of Burns in developing countries, especially in India (Chaurasia, 1981:2) projects the higher vulnerability of women in terms of incidence as well as mortality. Thus the cases of adult women admitted to S.S.G.Hospital comprise the universe of the study.

All the cases admitted during a period of one year June 1982 - May 1983 (N=227) (excluding those who passed away immediately (N=99) or were discharged/absconded against medical advice (N=25)) are included in the sample. The size of this purposive-census sample comes to 103 (N=103).

SOURCE OF DATA COLLECTION:

Hospital records, patients, family members or 'significant others' (where incapacity of the patient to communicate due to conditions of nervous shock) form the sources of data collection.

TOOLS OF DATA COLLECTION:

An interview schedule forms the tool for data collection in order to facilitate face to face communication. Sufficient scope was left to include individual reaction in view of the phenotypic nature of the inquiry.

PROCESS OF DATA COLLECTION:

The area of inquiry having both psychosocial as well as medico-legal significance, the data collection was done

with utmost care to ensure confidentiality. Adequate care was taken to establish rapport and to begin from where the respondent 'is' (was).

ANALYSIS OF DATA:

Many authors (Lasswell et al, 1952:31-32) have debated the issue of importance of quantitative vs qualitative nature of the content analysis. Qualitative content analysis (George, 1959:9-10) which has sometimes been defined as the drawing of inferences on the basis of appearance or non-appearance of an attribute... has been defended... for its superior performance in the problems of applied social sciences".

An attempt is made to analyse the data (not considering the issue as dichotomus !) at both simple quantitative perspective with mean and standard deviation to explain the generic aspects of the data. The case study material is used to portray the insight into specific phenomenon, especially in latter part of the study mean and standard deviation are used to explain the data where "Precision" is more relevant, while the case study material is used to highlight particular cases.

LIMITATIONS OF THE STUDY:

The sample is the first limitation. The cases who expired soon after admission and could not be included

in the sample were the ones with very high degree Burns and probably carried with them significant information. The study has a scope for modification in this area.

The data collection was carried out in the hospital for the purpose of feasibility. Home visits could have increased the reliability of data on housing and some other areas.

PRESENTATION OF THE REPORT:

The study is organized and presented in five chapters in tune with the objectives in order to follow the main theme of the study. The introduction comprises of the basic premises of the problem alongwith the magnitude of the problem. The available literature is used to discuss the medico-legal and socio-psychological aspects of Burns. The resume of the review of literature completes the first section of introduction.

The problem and procedure of the study form the base of the second section. Burns as both the cause and the consequence, of a psycho-social problem and role of immediate management in the same, bring out the problem and purpose of the study followed by the significance of the study and the objectives. The procedures of the study

include the research design, universe and the sample, tools and procedures of data collection, scope and limitation of the study followed by a note on the organization of the report of the study.

The second chapter presents the socio-economic profile of the respondents and attempts to probe into the 'person-in-situation' of the respondents in reference to the usual life style; kitchen arrangement, dressing, use of fuel and gadgets; health anomalies; Marriage; Age, choice, dowry; interpersonal relations in the family, status of satisfaction with present life, the problems faced in life in order to understand the predisposing factors creating conditions conducive to Burns.

A probe into the 'Episode of Burns' forms the theme of the third chapter. The inquiry covers the time, place, presence of others, activities and operations involved in, agent of Burns, precipitating events, special significance of the day (atypical situations) mood, emotional status, nature of episode; accidental, suicidal, homicidal, effect of crisis, mechanisms of coping and outlook in future.

Immediate Management by 'self and others' forms the base of the second section of the chapter. It describes the

ways the management of Burns was carried out by the victim as well as others. It also mentions the level of awareness about the proper management and the source of knowledge. Also detailed are medical aspects, treatment received, degree of burns, percentage of burns, areas affected, nature of the injury, source of heat and the prognosis of the cases.

The fourth chapter presents case studies of selected cases representing different dimensions of episodes of Burns.

The last chapter presents the salient findings, the conclusions and a few suggestions in the form of a note on the strategies of social-work intervention.