Clinically providing psycho-social care for caregivers in emergency and trauma care setting: Scope for medical and psychiatric social workers
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ABSTRACT
Traumatic brain injury is the leading cause of death and disability in young people. TBI is associated with increased mortality, morbidity, and socioeconomic loss, especially in developing countries such as India. It is creating damage to the psychosocial well-being of caregiver and their family members significantly. Caregivers’ informational, educational, psychosocial problems are still overlooked and unaddressed. Providing psychosocial interventions such as educating caregivers about TBI-related consequences, increasing social support, mobilization of resources for the needy, and dealing with psychological stress will be beneficial to reduce the caregiver burden. Medical and psychiatric social workers (MPSWs) have important role in providing psychosocial care and decreasing caregiver burden of TBI survivors. This case report highlights the role of MPSWs in the emergency and trauma care setting.

Key Words: Caregiver, psychosocial interventions, role of medical and psychiatric social workers, unmet needs

INTRODUCTION
Traumatic brain injury (TBI) is considered as a major public health problem worldwide, including in India. It is the leading cause of death and disability in young people. Majority of TBIs are due to road traffic accidents (RTAs). According to the WHO data, by the year 2020, head trauma will be third largest killer in the developing world. Severe TBI survivors suffer from physical, functional, cognitive, and psychosocial disabilities. So, involvement of families in rehabilitation and need for family intervention is recommended in the trauma care setting. The caregivers play significant role in taking care of the patient, recovery, and rehabilitation of TBI survivors. In the process of caregiving, caregivers experience various needs, i.e., informational, educational needs, role changes in the family, caregiver burden, psychosocial and behavioral issues. These unmet psychosocial needs demand multifaceted interventions and support from multidisciplinary health-care professionals.

Medical and psychiatric social workers (MPSWs) play significant role in the multidisciplinary team, especially in rehabilitation and trauma recovery. The MPSWs primary duties and responsibilities are to help the patient and family to cope with the crisis and improve the quality of life of persons with terminal illness and their family members in the hospital, home, and community. However, their role is not recognized adequately and role ambiguity present in the team. Therefore, the purpose of this paper is to provide basic understanding and suggest few feasible psychosocial interventions that can be provided for TBI caregivers during hospitalization in emergency and trauma care setting from medical and psychiatric social work perspective. Written informed consent was obtained from the caregivers to describe their case details for this publication.
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Consent was obtained from caregiver for publication purpose.

CASE REPORT

Ms. XZ was a 28-year-old female, married, educated up to undergraduate level, and homemaker by occupation. She hailed from a low socioeconomic family background from Vellore district, Tamil Nadu, India. Her 34-year-old husband (YZ) was the bread winner of the family. He was working as a daily wager in the vegetable market. They had no children.

The patient had met an accident on May 12, 2016, at 3.30 pm while riding on a two-wheeler along with her sister. The accident was alleged with two-wheeler hit by a three-wheeler. Patient was unconsciousness soon after the accident. Her Glasgow coma scale score was 6, whereas her sister had sustained mild injuries on head. Patient was taken to nearby hospital for first aid purpose. From there, patient was referred to specialized tertiary care hospital in Bengaluru, India, for further treatment which was 250 km away from the accident place.

She was evaluated by trauma care team and diagnosed suffering from traumatic right frontotemporoparietal acute subdural hematoma (SDH). She underwent right frontotemporoparietal craniotomy evacuation of acute SDH and augmentative duroplasty. Post scan showed good evacuation of acute SDH. Following which she developed wound discharge postoperatively. Thus, subgaleal drain was placed and antibiotics were started for surgical wound site infection according to culture sensitivity. Tracheostomy was also done and decannulated after 10 days. Patient was being discharged on antibiotics in a stable condition. Figures 1 and 2 show the computerized tomography scan images of the TBI survivor.

Most of the time, neurosurgeon role is limited to look after medical aspects of the TBI survivor. They are not fully equipped to address the severe and yet sensitive issues such as emotional and psychosocial issues. Surgeons need to provide information before and after surgery, but doctors are often reluctant and not interested to give required information to patients and their family members related to surgery and to understand their day-to-day concerns.

Patient’s husband (hereafter referred as caregiver) was emotionally overwhelmed during hospitalization. Hence, the treating team referred the case to MPSWs for detailed psychosocial assessment and to initiate the psychosocial care for the caregiver.

Psychosocial need assessment

Soon after the referral, the psychosocial need assessment was carried out with the help of biopsychosocial approach. Her husband was the only caregiver in the hospital. He was emotionally disturbed and not able to accept the trauma. He wanted to see her back in normal stream of life. He further added that in his own words, “I can’t live without her, please save my wife...cried.” Further, assessment found that his family belongs to below poverty line and had financial constraints to meet the surgical cost and day-to-day medical expenses in the hospital. They did not have savings and living in a rented home. No financial support was received from known family members and relatives to meet treatment expenses.

Besides that, caregiver had poor knowledge about illness, high expectations with respect to prognosis, poor coping abilities, and inadequate social support. He posed several queries regarding prognosis and rejected consent for surgical interventions. Multiple crying spells were noted during the interview. Further, Depression, anxiety, stress

Figure 1: Computerized tomography scan plain brain preoperatively showing right frontoparietal acute subdural hematoma with midline shift

Figure 2: Computerized tomography scan plain brain postoperative status showing frontoparietal craniotomy and evacuation of acute subdural hematoma with no midline shift
21-item scale revealed mild depression; high levels of stress and anxiety were observed. Day-to-day caregiving responsibilities increased his burden. He struggled with sleep difficulties during hospitalization and uncertainty about the future persisted.

The following objectives were set prior to the psychosocial interventions based on the assessment:[1] to impart the knowledge about TBI in caregiver;[2] to help financially to undergo medical treatment;[3] to enhance social support to caregiver during hospitalization;[4] to deal with psychological trauma that occurred due to RTA/TBI;[5] to help and teach stress and anxiety-relieving techniques to the caregiver. The psychosocial interventions were provided over a period of 1 month during hospitalization. Each session lasted for 30–45 min on a daily basis in a separate room as per caregiver convenience.

**Psychosocial interventions and outcome**

The MPSWs team spent with quality time after establishing rapport with the caregiver. Following that, counseling was provided covering various issues in general. The next session focused on educating the caregiver about brain anatomy, its functions, diagnosis, and outcome. He was also educated about psychosocial consequences of TBI. The index family was suffering from poverty and had financial constraints to meet medical expenses. Thus, MPSWs involved in contacting philanthropists and hospital administrations to facilitate free treatment for the TBI survivor. He was emotionally and physically tired with caregiving responsibilities and duties in the hospital. He was in need of help to share his caregiving burden. Thus, the respite care was arranged by contacting her sister. Add to that, he was involved in peer supportive group meetings, especially designed for TBI caregivers in the hospital on a weekly basis. This helped him to share his feelings and get relieved emotionally and learn new tasks from other peer caregivers. Subsequently, trauma counseling was provided to address the trauma reactions. The relaxation techniques were taught for caregiver during hospitalization to reduce the stress, anxiety and cope with depression. This helped caregiver to ventilate his personal feelings and emotions with the therapist. He was consoled and comforted through trauma counseling and learned to cope up with trauma reactions better. At the time of discharge, the disability certificate was issued to the patient and guided caregiver to access disability benefits in the respective states. Furthermore, he started advocating the importance of wearing helmet while riding to fellow peer group, friends, and others in the hospital voluntarily. The MPSWs had given contact number to the caregiver at the time of discharge. The caregiver was assured and free to contact MPSWs team for further help. Table 1 depicts the details of psychosocial interventions that were provided to the caregiver.

## DISCUSSION

The case study was aimed to elicit the psychosocial needs of caregivers of persons with TBI and provide appropriate psychosocial interventions to address the same during hospitalization in emergency and trauma care setting. The caregiving is done by trained workforce in developed countries; in resource-poor countries like in India, caregiving is most of the time left to the family members. Family caregivers are family members, friends who care for their ill members.[17] One of the priorities at times of emergencies is to protect and improve people’s mental health and psychosocial well-being.[18] Different departments contributed to TBI field by doing research, but MPSWs contribution to TBI field in India is still in the dark side.[12] There are several reasons for this such as; inadequate provision of upgrading knowledge, skills, minimal level of cooperation from the hospital administration, limited assistance from doctors, poor incentives for MPSWs, and role ambiguity in psychosocial care delivery.[12,19] From this point, the present study is unique, carries significance and highlights the role of MPSWs in the emergency and trauma care setting.

This present study identified several psychosocial needs. In our case study, we observed that caregiver informational and educational needs were unmet. This finding is similar to other studies reported that informational, emotional, and professional supportive needs are highly ranked and unaddressed. This resulted in postponing the surgery, uncooperative to surgery by TBI survivors and their family members. The studies also have cautioned that psychological screening should be routinely applied on patients and families of spinal cord injury. It can be generalized to other neurosurgical conditions too.[20,21] Educating about TBI, basic anatomy and its functions, causes of TBI, name of the diagnosis, prognosis of TBI had enhanced caregiver knowledge and brought acceptance of the illness. Add to that it also motivated him to take the caregiving responsibilities in the hospital, and became an active advocator to bring awareness on TBI among peer group. Patient and caregiver education prepares indexed family to face the crisis in a better way reported elsewhere.[19]

Our study further found that TBI affected the productive age group and left severe financial crisis and disability in the family. Studies showed that most of the time, severe injuries and neurosurgical conditions are associated with increased mortality, morbidity, significantly inducing disability, and socioeconomic loss in developing countries including in India. The disability benefits which are applicable to physically challenged people can also be applicable to the persons with neurological disability.[10,22,23] Thus, we strongly suggest that MPSWs should take lead role in assisting, ensuring, and access
disability benefits for eligible persons and guide the caregivers appropriately to access the same.

The study also highlighted that getting social support for TBI survivors and their families was difficult. Support systems are inadequate and unmet for TBI survivors and their family members.[10] The study further described various psychological reactions such as weeping, increased stress, anxiety levels, and mild depression. This finding was supported by other studies that psychological distress, especially depression and anxiety have found common in TBI caregivers.[23] In addition, simple explanation of psychological consequences of trauma and improving self-efficacy helps patients and family members to handle trauma reactions better.[24] Further, providing adequate social support for caregivers in the hospitalization moderates to deal with caregiver distress, stress, and anxiety. Supportive group meetings can form platform to caregivers and the family members to share their experiences, ventilate their feelings, and learn to handle the practical difficulties and new caregiving tasks.[25]

**CONCLUSION**

Psychosocial needs of caregivers of TBI survivors remain overlooked. Providing psychosocial care in the emergency and trauma care setting is paramount. Hence, every TBI survivor and their families must be referred to MPSWs by neurosurgeon for psychosocial screening, assessment and for appropriate psychosocial interventions. MPSWs should take the responsibility to ensure maximum utilization of resources and successful rehabilitation measures for the needy and to provide therapeutic help for distressed caregivers from strengths perspective. In addition, MPSWs should make efforts to bring the awareness to reduce the risk of RTA by arranging public awareness camps in various settings such as schools, colleges, in general public and in the communities is essential. The caregivers may be encouraged and invited to be an advocators for the same cause if they are willing. Thus, we conclude that MPSWs must be involved in the emergency and trauma care setting to provide psychosocial care for the needy. Yet, generalizability of psychosocial interventions provided in this article is cautioned.

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**Conflicts of interest**

There are no conflicts of interest.

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