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The following article is the first in a two-part series exploring the time-honored but sparsely analyzed or documented concept of providing school reentry programs for burn-injured children. In this first article Dr. Pat Blakeney provides us with the psychological and developmental rationale supporting the need for such an intervention, a brief literature review outlining the development of school reentry programs, a pragmatic, detailed statement of essential program components, and recommended audiovisual and printed resource materials.

The second article (in a future issue) will focus on program evaluation. Clinically, school reentry programs are accepted by most as both an ethical and valuable intervention. Can we objectively determine the effectiveness of providing this comparatively time-consuming service?

The Nursing Forum (in a future issue) will feature a complementary discussion of school reentry from the perspective of the nurse/case manager and her role in working with play therapists and other team members involved in providing reentry programs.

Our compliments and appreciation to Dr. Blakeney for these comprehensive user-friendly articles. Readers are encouraged to submit any critique or related information regarding their own approach to school reintegration programs and especially any program evaluation results.

School Reintegration

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School reintegration programs have been developed to enhance a positive sense of self-worth in a child who has been burned. The premise of these programs is that cognitive and affective education about children with burns will diminish the anxiety of the patient with burns, the patient's family, faculty and staff of the school, and the students. Five principles guide school reentry programs: (1) preparation begins as soon as possible; (2) planning includes the patient and family; (3) each program is individualized; (4) each patient is encouraged to return to school quickly after hospital discharge; and (5) burn team professionals remain available for consultation to the school. Reintegration programs can vary in format depending on patient and/or family need and capability of the burn team, thus allowing flexibility in assisting every child with burns make the transition from hospital patient to normal living. (J BURN CARE REHABIL 1995;16:180-7)

SCHOOL REINTEGRATION

Preparation for the pediatric patient with burns to reenter society begins almost as soon as the child is admitted for acute care and becomes more intense as discharge becomes more imminent. The spectre of returning home and resuming life outside the hospital can be frightening for the child who has survived a burn injury, especially if that injury renders the child visibly changed and different from other children. During hospitalization he has been surrounded by people accustomed to seeing burn scars, pressure garments, and face masks. His peers have been other children who were burned. Although he longs to go home, when faced with the reality of leaving the protective environment of the hospital, the patient becomes anxious.

Depending on the child's developmental capability

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and personality, the expression of this separation anxiety varies. Whereas one child withdraws and seems sad, another child rages against his fears, striking out at all those who care for him; still another actively resists rehabilitation exercises and refuses to eat. Occasionally, the older child or adolescent may say clearly, "I don't want to get well and leave the hospital. I'm scared." More often, however, to give voice to the fears is in itself frightening, and the child relies on sensitive and knowledgeable adults to detect his fears and help him express his ambivalence. The fears most often relate to how others will react to the child's changed body. Loving family members share the child's fears of rejection and ridicule. Wanting to protect the child from hurt, they worry about taking the child into a world where disfigurement is shunned or denounced.

Indeed, children—and adults—can be rude and mean. Patients and families returning to the burn center for follow-up report anecdotes of social cruelty. Strangers do stare at the burned child; friends and relatives do withdraw and are no longer available as they had been before the injury. Friends, relatives, and strangers alike do make hurtful remarks.

Usually such cruelty stems from lack of familiarity with burn injuries, curiosity at seeing something never seen before, and anxiety at not knowing what to say or do in this unfamiliar situation. People feel frightened that they, too, could be so injured and attempt to defend against their own feelings of vulnerability by creating psychological distance between themselves and the injured person.

TRANSITION TO THE COMMUNITY OF SCHOOL

Armed with information about hurts that others have experienced, the burn care staff can intervene to ease the patient's transition from hospital to home. Interventions should begin early in the child's hospitalization, with three primary targets: the patient, the patient's family, and the patient's community. The "community" that dominates a child's life outside the family is school. School is the domain in which the child develops academic skills, social skills, and a sense of self-worth. As the burned child struggles to develop a new self-image that incorporates his scars, he needs feedback from within his school community that tells him that he is valuable and competent.

Yet school personnel quite likely have no information about or experience with burn injury and recovery, and they are susceptible to all the fears, anxieties, and failings of human beings. Teachers' concerns about having a burned child enter their classes are similar to those identified for teachers of children with cancer.[1] Teachers worry that a burned child will require too much specialized attention and that they will be inadequate in meeting the child's needs. Teachers worry that the other students will be insensitive to the burned child or will be frightened by his appearance. They worry that they do not know what can be expected of the injured child, what special needs he may have, and what his physical limitations are. To address the fears of the patients, parents, and school personnel, burn treatment programs have developed formal, organized programs for school reentry and reintegration.

SCHOOL REENTRY OR REINTEGRATION PROGRAMS: GUIDING PRINCIPLES

Programs to ease the transition from hospital to home and school have been developed (1) for patients treated in different types of hospitals, (2) for different community settings, and (3) with professionals from different disciplines who carry major responsibility for the management of the program. In spite of their historical diversity, the programs are remarkably similar. They share the common goal of preparing the injured child, the child's family, school personnel, and the child's peers for the patient's transition back into the normal routine of attending school. The underlying premise is that education about burn treatment and about needs and limitations of the burned child will diminish anxiety related to the unknown. Enhancing the students' identification with the burned child and helping the students prepare for their injured classmate's arrival typically will diminish anxiety and awkwardness. When anxiety decreases, the need for defensive behaviors such as withdrawal and ridicule will also decrease and the burned child's peers will be more accepting and supportive of him. A few guiding principles are reiterated throughout the scant literature on school reintegration.[2-5]

Principle 1: Planning for School Reentry Begins as Soon as Possible. From the time of the child's acute admission to the hospital, his return to school is part of the treatment and discharge plans. A member of the burn team discusses academics with parents in early interviews and, with their permission, contacts the child's home school to notify the school of his medical status, to obtain useful information about the child's academic achievements, and to elicit any concerns from the school personnel's point of view. The reintegration process begins with that first contact and is further refined through the cooperative efforts of school, hospital, and parents.

School instruction of some form is incorporated

into the child's daily treatment as early as his condition allows. Ideally, the hospital has a school program, but if not, school work can be forwarded from the home school and a parent or staff member can be the "teacher." School is a big part of the child's life, and it is essential that he be impressed with the idea that he is expected to resume a normal life. One child reported about her time in the hospital, "I knew I wasn't going to die because you kept making me have school."

Principle 2: Parents or Guardians of the Child Should be Empowered to Actively Participate as Appropriate Advocates for Their Child. Families that value autonomy of individuals and encourage individual expression within the context of family cohesion seem to provide an environment that is most conducive to positive psychosocial adjustment of children.[6,7] Work with the burned child thus means involving the family in the child's treatment so that the parents or guardians feel competent to care for the child outside of the hospital setting. Work with the families must include training not only in wound care but also in providing a supportive and positive psychological milieu. A part of the family work is to focus on the importance of supporting the child in his return to school as soon as possible—usually within a few days of discharge from the hospital.

Principle 3: Each Plan for Each Child Should be Individualized. Each child has his own needs and his own resources within the context of his unique situation. Age and developmental level of the child, visibility of the burn scars, degree of physical impairment, the child's previous level of psychological and social functioning, the make up of the community in which the child lives, the size of the school, the distance of the school from the hospital—all must be considered in designing the reentry program for the child. There are many different decisions to be made. Does the situation demand a visit to the school by members of the burn team? If so, who should go? Is such a visit affordable? What teaching aids should be used? Does the child need a videotape showing his changed image to prepare everyone at school for his new appearance? Who should be visited—the whole school, only his grade, the PTA? Each child and each situation present different needs.

Principle 4: Each Child is Treated as if He Will Return to School on Discharge. The burn team wants to convey to the child and his family that the burn injury is only a temporary disruption to his life. He may have to learn new ways of doing some things, and he may have to move at a slower pace than in his preburn days, but he can resume his activities and, with time and practice, will be able to participate. A quick return to school for even a small part of the day reinforces the idea that the child is again able to begin normal life with his peers. Most important, the child cannot be allowed to withdraw into the safety of isolation, receiving no new information and no feedback from others. The child who is allowed to withdraw experiences each day of isolation as confirmation that he is in fact incompetent, without value, and repulsive to others.

Principle 5: Continued Availability of Burn Team Professionals is Necessary for Communication With School Professionals as Problems Arise. A part of the school reintegration program is to identify for school personnel the person(s) on the burn team who will act as liaison. Teachers are more likely to report difficulties or ask questions if a resource person has been identified. Changes in the child's school situation or rehabilitation treatment regimen may necessitate renewed efforts from the burn team to ease the child's transition.

ELEMENTS OF SCHOOL REINTEGRATION PROGRAMS

Although there may be many good school reintegration programs for burned children, only a few have been described in the literature or in professional meetings. Probably the first such program was that described by, and primarily developed by, Sue Cahners[2] at the Boston Unit of the Shriners Burns Institute. She recognized that teachers "like the vast majority of people untouched by fire, do not understand the problem, are afraid to approach the problem, and feel threatened by the need to deal with it." Cahners centered the Boston Shriners Burns Institute reentry program around visits to each child's school where she, or someone with similar sensitivity and skill, could assist the teachers and classmates to deal with feelings that might hinder their ability to assist in the reintegration process.

Reintegration programs were developed in other burn centers in a similar fashion as staff recognized needs of their young patients. As each program developed within different parameters, multiple modalities were used to provide information and address the discomforts of a school community unaccustomed to burn scars and pressure garments. At the North Carolina Jaycee Burn Center, representatives of any or all allied health disciplines involved in the child's care accompanied the child in an on-site school visit where the child actively participated in presenting information about burns and burn treatment, demonstrating any splint or special garment he wore.[3] At Children's Hospital in Denver, Marion Doctor has advocated school visits by a team combining medical and psychosocial staff. Typically the

visit includes a meeting with school personnel followed by an assembly for the entire student body and/or the patient's classmates; the patient and the patient's family participate in both the preparation and the on-site presentation.[4,5] The Shriners Burns Institutes in Cincinnati and Galveston developed reentry programs for populations who were often at great geographic distances from the burn centers. Because the cost of travel and the time required for staff to be away from the hospital prohibit school visits for every child, these two centers rely heavily on written materials, phone calls, photographs, slides, and videos. School visits have, of necessity, been reserved for patients with the greatest needs.

All of these programs include the same basic elements: (1) They address the school administration, the classroom teachers(s), and children. (2) They include the patient and family in planning and, to some extent, in presenting. (3) They present generic educational information. (4) They present specific information about the individual child who is returning. (5) They direct the presentations at both the intellectual and emotional issues surrounding the return of the burned child.

PRESENTATIONS OF GENERIC INFORMATION

Written Materials. Written materials are an efficient way to convey information. Booklets mailed to the school early in the child's hospitalization provide the personnel with salient information, allowing time for the readers to process the information and formulate questions or voice concerns before the child's return. One excellent example is the *Back to School* booklet used by both the Galveston and Cincinnati Units of Shriners Burns Institute. This booklet was originally developed primarily by Mary Knudson-Cooper who, as a behavioral scientist, a burn survivor herself, and the mother of two burned children, brought a special insight into the needs of burned children interfacing with an unburned community. The booklet contains information about burn injury including a glossary of terms; physical, emotional, and social problems; and advice on how to help a burned child return to school. It addresses questions frequently asked by teachers such as, "Why not a homebound program?" as well as those that are expected to arise after the child is back in the classroom, such as, "What do I do about itching?" this booklet has been modified several times over the years to keep it current. The most recent—and best—version at this time has been created by Kathy Washam and the reentry team at the Cincinnati Unit of Shriners Burns Institute.[8]

Washam and the Cincinnati team emphasize the involvement of parents in their own child's reintegration and have developed another fine booklet, which provides guidelines for parents as they plan for their injured child's return to school.[9]

Audiovisual Materials. The old adage about the worth of a picture is certainly true in the case of preparing those unfamiliar with burn injuries for an introduction to a burned child. It is impossible to describe simultaneously with words alone both the horror of disfigurement and the attractive qualities of a child. Scars, amputations, prostheses, pressure garments, splints, and masks may combine to create a visual image that is strange and frightening to the naive observer. Photographs and slides have been very helpful in school reintegration and serve both to provide information and to help the audience become accustomed to viewing these unfamiliar sights.

In the last decade the popular use of videotapes has been a great asset. Video allows the viewer to experience burned children in a way that most closely approximates reality. The viewer can hear the voices, see the children move, and glimpse the personalities of the children as they express themselves. At the Galveston Unit of Shriners Burns Institute, we have relied heavily on the use of video both with and without a school visit. In fact, the videos are particularly valuable when a visit is not possible.

Four recent videos are excellent examples of the use of this medium to address generic issues related to burned children. *Brandon*[10] features a 6-year-old boy with significant cosmetic and functional difficulties who has suffered a severe burn. The video follows him through typical activities in school and at play. The voices of his family members and his best friend as well as his own voice tell others that he can be a good friend and give advice about how to relate to a burned child. *Meagan*[11] is available on video or as a slide-audiotape show, the format in which it was originally developed. This presentation was developed for reentry with early school age children (K-4). It features a 7-year-old girl who describes how some children tease her and how she feels; in addition, it uses pictures of many patients to describe what happens as a child goes through recovery and it demonstrates splints, pressure garments, mask, and prostheses. *Going Home*[12] is a short video actually developed for pediatric survivors of burn injury to assist in the arduous task of motivating them to comply with wearing pressure garments. Containing interviews with several burned children who speak about themselves, it also can be useful with nonburned friends of burn injury survivors by helping the friends understand the importance as well as the discomfort of wearing the garments. *Through the Eyes*

of a Child: Burn Recovery[13] also features burned children talking about themselves, how they cope, and how they are able to participate in life in spite of "disability." Most of this tape was photographed at Camp Cheley in Estes Park, Colorado, and illustrates clearly that burned children can be active and have fun. Unburned counselors also describe their feelings at meeting the children initially, and thus it is helpful in presentations in preparing other unburned audiences for that experience.

Photographs, slides, and homemade videos are used not only for generic education but also to educate specifically about the individual patient. The *Meagan* slide series allows space to insert slides of the individual child who is the target for reintegration. When a school visit is impossible, the slide-tape show can be sent with slides and a brief script specifically for the individual burned child who will be joining the school. Individually made videotapes featuring the specific patient are very effective in introducing or reintroducing the child to his peers. The child and his parents help plan what is to be included in the tape, and the child is encouraged, not pressured, to talk to his classmates, telling them whatever he wants them to know. A tape also may demonstrate the child's prescribed exercises for the local family and therapist.

Other Teaching Aids. In conjunction with school visits, there are many creative ways to use materials to graphically portray aspects of burn treatment and recovery. The more that children can be actively involved, the greater their learning and comfort levels will be. Dolls can be used to illustrate the application of splints or a face mask or garments; dolls also can be outfitted with a "graft" and a "donor site" attached by fabric touch fasteners. Encouraging the unburned children to try on a face mask or a splint or a pressure garment enhances their ability to empathize and sympathize with the burned child. The materials and activities used to facilitate empathy are limited only by the imaginations of the burn unit staff.

CONTENT OF PRESENTATION TO SCHOOL

Whatever the format of presentation, there are certain content areas that must be addressed in writing, in telephone conversations, on videotape, and in person. The words and methods used to communicate will vary with the targeted audience, but the content remains the same.

1. What Happened to Cause the Injury? Explaining the cause of the burn is important in dealing with older children and older audiences. It is also important to include the injured child and his parents in deciding how much information to give. The emphasis in the explanation should be that accidents do happen and that the child is not to be blamed for being burned. For young children a limited explanation that is not too frightening is sufficient and preferable.

When the cause of injury lends itself to a lecture on burn prevention, it is important to remember that the goal is to facilitate the burned child's return to normality, not to use him as an example of what happens when you make a mistake. Burn prevention can be addressed without blaming the child.

2. What Happened in the Hospital? Although there is no need for detailed descriptions of burn treatment, it is helpful to relate information about the hospital to reassure the audience, who often are as frightened by the idea of a hospital as they are by the idea of an accident. Without being dishonest about procedures, that are frightening or painful, one emphasizes that the doctors, nurses, and therapists all took care of the child, that his parents were with him, and that he had friends and toys to play with while he was in the hospital.

3. Scars. Age-appropriate explanations of scarring demystify the burned child's changing skin and provide the reasons for the necessity of wearing his special appliances and garments. In discussions of scarring it is important to acknowledge explicitly that the scarred area has a different color and a different texture from unscarred skin, and to normalize these differences. If the burned child is comfortable with the idea, it usually is very helpful to suggest that he invite others to touch his scars. Once children have experienced touching the scars, they usually feel more comfortable with seeing the scars.

4. Splints, Masks, Pressure Garments, and Other Appliances. Knowing that the burned child wears these weird-looking, uncomfortable devices to continue getting better, the nonburned classmates not only accept the strange garb but often can be recruited to help by reminding their friend to wear his mask or glove. The more familiar the class becomes with how it feels to wear a mask all day (or a splint or a pressure suit), the more empathetic they can be.

5. What the Child Can Do. A burned child returning to school may need extra time and some help to accomplish certain tasks, but he should be encouraged to do independently all that he can and be expected to participate as a competent child. Most children who have been burned will try, at least once, to gain special dispensation by claiming that "Burned children can't. . . ." It is of paramount importance that the child's capabilities be made clear and emphasized.

6. What Friends of the Injured Child Can Do. If there are ways that the child needs help, those can be listed clearly. Classmates and teachers alike usually are grateful for directions about what to say or how to help an injured child. In consultation with the burned child, the burn team can give concrete suggestions to the class about what questions are okay to ask their injured classmate. Most children and adults want to be supportive, but if they have no ideas about what to say or how to relate, they will likely withdraw from the discomfort of an awkward situation. They need specific guidelines from the experienced burn team.

7. The Burned Child Looks Different on the Outside, but He is the Same on the Inside. Not only is this statement made explicitly in every school reentry presentation of a burned child, but it is the implicit theme throughout the presentation. Every aspect of the presentation is designed to explain the external differences resulting from burns and to guide the unburned toward identifying with the burned child and imagining themselves in his situation, thus enhancing empathy as well as sympathy.

TO BE CONSIDERED

Special Issues for the Faculty of the School. Teachers and school administrators usually are concerned that they will be inadequate in meeting the needs of the burned child. It is especially important to give them information about the child's capabilities and specific details about his rehabilitation needs as they relate to the hours he will be in school. If he is receiving medication, they will need to know how that medication may affect his classroom activities. School personnel need to know that except for the school nurse, they are not expected to give medical care; and the nurse is not expected to be an expert in burn care. All concerned need to know that they can depend on calling the burn unit for help if they feel the need to do so.

Special Issues for the Burned Child. No matter how much planning and preparation work has been done to ease the burned child's transition back to school, he will still be worried about that first day back. Bland reassurance is not helpful, and it is not reasonable to expect the child will stop worrying. I usually ask the child to keep an accounting of every occasion in which someone at school hurts his feelings; I want to know who did it and what was said or done so that we determine how to deal with such events in the future. Giving the child this structure for worrying along with the promise of helping him cope seems, paradoxically, to relieve some of the tension. He does not stop being anxious, but he and his parents become more comfortable with allowing him to have normal anxiety.

Special Issues for Preschool and Early Elementary School Classmates (K-2). Young children are curious and involved in learning about everything. They also are remarkably accepting of other children no matter what the differences. When their questions are answered, they can feel more secure and recognize what they all have in common. Within this age group, children develop new fears about their physical comfort and safety and project these fears even onto old and familiar objects. The introduction of an injured child and discussion about that child's accident may elicit unexpected fears in a child. It is important to word explanations to this age group in a way that makes what happened seem more acceptable, with reassurances that the hurts of their classmates can be healed and their friend can play with them.

Special Issues for Older Elementary School Classmates (Grades 3 to 6). Older children become more aware of their social liaisons and form social groups that, by definition, exclude someone. Teasing and nicknaming are prime modes of defining the boundaries of the group, and physical appearance is an easy way to differentiate among their peers. Fortunately the boundaries of the groups at this age are fairly fluid, and one may be "out" today and "in" tomorrow. Because children want to be good, they can be motivated to be helpful and supportive of each other. Activities that help them identify and empathize with the hurt child are especially helpful in this age group.

Special Issues for Adolescents. This age group has the most difficulty in dealing with differences among themselves. Healthy adolescents are insecure about their normally changing bodies. As they begin to develop secondary sex characteristics, forming "romantic" relationships becomes a dominant theme in their lives. With so much rapid change and insecurity, adolescents cling to their peers for reassurance; peer approval is of paramount importance. Any child who may detract from the perceived attractiveness of the group is a threat to each individual in the group and therefore likely to be excluded. A teenager who has been burned has many complex body image issues to resolve. In addition, his disfiguring scars put him at high risk for social exclusion during a very difficult time.

Individually and in small groups adolescents are more relaxed about accepting a friend who looks different. With this age group it is important to connect with as many helpful resources as possible. Reintegration efforts may be directed not only to the school but also to the specific groups with whom the student identifies such as a church group, athletic

team, or drama class. School counselors and/or local psychotherapists, physical therapists, and occupational therapists can all be included to receive information and consultation from the reintegration team to enhance the probability of multiple supports for the burned adolescent.

PRACTICAL ISSUES

When to Schedule Reintegration Program. The actual presentation of audiovisual materials and/or a school visit should be scheduled for a time immediately preceding the child's actual return. It is important that information about the child and his capabilities be accurate and current. If presented too early, the information presented may create a false picture of the child that will have to be corrected.

There have been occasions when, for some reason, a child's reentry presentation occurred several days after he had returned to school. From these experiences we have learned that if it is impossible to prepare the school before the child's return, it is still valuable to proceed with the presentation after the fact. We have had reports from both children and teachers in these instances that before the presentation, the child had been the target of some teasing and name calling, which ceased after the presentation.

Whether to Have the Burned Child Present During the Reintegration Presentation. This is a decision to be made on an individual basis with the child and his parents. In general our choice is to do the presentation without the child being there. The other children and the faculty tend to ask many more questions and become more actively involved in the learning process when they are not anxious about hurting the injured child's feelings or worried about bringing up thoughts that will make the child sad or otherwise uncomfortable.

There are children who are eager to be present during the meetings with their peers and can be very good advocates for themselves. Some centers regularly include the child in his own reentry presentation.[3] There are no objective data that indicate a preferable choice in this decision.

Including the child's parents in the presentation to the students may be helpful. Teachers report that the parents' participation in relaying information is helpful whether or not the parent can be physically present during the presentation. From a psychological point of view, the more parents can actively and appropriately participate in any aspect of assisting their burned child during difficult times, the more competent and confident the parents are likely to feel. These feelings have a positive impact on the whole family, including the burned child.

Which Members of the Burn Team Should Make a School Visit? Several factors may determine the choice of which burn team professionals should visit the school. In general, the tasks to be accomplished guide this decision within the parameters of budget and time limitations. Whoever makes the actual visit is representing the whole burn team and must be able to be spokesperson for multiple disciplines with varied perspectives on the physical and psychosocial aspects of the patient's recovery. Clearly written guidelines and checklists for what should be accomplished during a visit can serve as a "script" that any team member can follow so that each issue is addressed with basic information and competence. This allows the team flexibility in deciding who should make the visit.

Who is the Audience for the School Reintegration Program? The purpose of the reintegration program is to ease the transition of the burned child from hospital to school. Anyone who will interact with that child may appropriately be considered as someone who could benefit from a more educated understanding of the needs of the child as well as guidance about how to relate to him in a supportive way. The targeted audience can be expanded to include extended family, neighbors, church groups, or whomever is important to the child in preparation for his return. This is a stretch of the concept of "school reintegration" but can be very important to the child's community reintegration.

Within the school itself, the administrators, teachers, and counselors who will be working with the child must be included. If there is a visit by the burn team, the visit should include a meeting with these faculty separate from the rest of the school and, if possible, before a meeting with the students. The faculty need a time in privacy to voice their concerns and ask their questions and, ideally, be reassured and optimistic before meeting with the students.

Which students will be included depends on the situation of the school. If possible, it is ideal to include the whole student body because all students are likely to see the child before or after school or in the cafeteria and their questions need to be answered. Whether or not the whole school is included, the class or classes in which the injured child is enrolled must have their own special time to process information and plan for the entry of the student.

Some special people at the school do not fall into the categories of faculty or student but need to be included in some way. Cafeteria workers, office sec-

retaries, janitors, bus drivers, and other employees may have a great deal of informal interaction with the students. Another important group are parents of other nonburned students. Parents are often uncomfortable with the idea of their children being in school with a disfigured child, and their influence is obviously very strong. Whether invited to attend the program with the students or to have a separate meeting in which to receive information and deal with their concerns, they must be included as an influential part of the reintegration program.

What If a Child or Parent Refuses a School Reintegration Program? Sometimes a child or parent is frightened by the idea of so much special attention being given to the child. They fear that calling attention to the child's injuries will create or worsen the problem. Usually through explanations of what will happen during the presentation and how such programs have been helpful to others, the parent relaxes and agrees to participate to a full extent—if the child agrees. And there are times when the child is extremely resistant. Arguing and cajoling are useless in these situations. The child will simply play the part that any normal person plays in a power struggle: he will become more determined to win the struggle. Adolescents, so insecure in being different from others, are especially apt to make the argument that they do not need a special presentation to the school. One boy who had lost a hand insisted that he would just keep that hand in his pocket all the time so no one would know about the loss!

In such a situation it is important for the burn team to back off but not give up. Every child can have a school reentry program. Sometimes that program may be altered to include a period of homebound instruction while the child and family gather energy and settle into their own recovery rhythm. The burn team continues with the goal of helping the child reintegrate socially beyond the limits of his home but must look for ways to motivate and reassure the child and family.

We can offer alternatives in how we implement the reintegration program. An adolescent refused to allow a videotape to be made of him but did agree to make one of himself in privacy. The team worked with him to suggest commonly asked questions he might want to answer and issues he might want to address. Then they gave him a blank videotape. Alone, he talked into the camera, voicing his ideas and feelings to his classmates, and he produced a very good reentry video that he allowed to be shown at his school by a favorite member of the burn team whom he trusted to answer questions and discuss the situation with his friends at school.

Usually parents and children agree to whatever the team suggests. When they do not or when they resist one particular aspect of a plan, it is important to remember that our role is to use our expertise to assist them in their lives, not to dominate their lives. They do know their lives at home better than we do, and they just might be right!

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