Supervising Medical Social Work Interns in a Veterans Medical Center Hospital

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Abstract: This paper presents a narrative compilation of real social work student experiences through a pair of fictitious medical interns—"Michelle" and "Dwight"—assigned to simulated practicum education placements. Exploring Michelle's work in the burn unit and Dwight's in the traumatic brain injury unit, we consider the emotional challenges interns weather in the face of extreme physical trauma and how faculty supervisors can provide support.

***Keywords*:** practicum education, trauma, military rehabilitation

Introduction

Military personnel who are exposed to combat may experience cognitive as well as physical traumas. The field of medical social work has returned to the forefront after COVID-19 spotlit the value of medical care teams armed with person-in-environment theory. Training interns to tolerate traumatic injuries ("traumatic" in both the physical and emotional sense) is critical to their ability to work effectively with service members and their families. Since most post-hospitalization rehabilitation occurs at home within the context of the family, it is essential for interns to develop a holistic approach working with both the patient and the patient's loved ones to ensure sustained recovery. A component of treating patients and their families is encouraging them to partake in self-care. Thus, it should be evident it is imperative for student interns to do the same; it is crucial for student interns to incorporate regular self-care and belonging to model effective strategies for clients and address the associated stressors in their environment (Ericksen et al., 2021). This paper will address how field instructors can facilitate their students' processing of the stress they encounter during placement experiences.

Burns

A social work student intern placed on a military burn unit will need to focus on several things. Of these, two are paramount: 1) the individual patients' tolerance for pain, and 2) coordination with the family caregivers, who will be responsible for the patients' well-being after discharge. These both challenge the student to manage their feelings with exposure to the patients' trauma and to provide concrete physical support (i.e., medical care) as well as emotional support and relevant resources (i.e., social work) to patients and their families.

A burn injury is considered a *signature wound* (Zoroya, 2008), common to the point of emblemization, among the physical traumas experienced by military personnel. Burns are a common result of detonated improvised explosive devises (IEDs): homemade explosives made with a fuel source (e.g., fertilizer, gunpowder), an oxidizer to ignite the fuel (e.g., ammonium nitrate), and usually an enhancer (e.g., shrapnel, metal fragments, nails) to inflict damage from flying debris. IEDs are designed to kill, maim, and incite terror, and they may be released in the

form of an expectedly dangerous pipe bomb or an innocuous-looking package—or entire delivery truck (Atkins, 2006).

It is important for the intern to learn the vocabulary of the medical unit. Social work students must be able to ask questions and understand conversations about the patient's burns. Thus, scientific, technological, engineering, mathematics (STEM) terminology and concepts, as applied to the patient's health (H), are requisite. The translation of information learned at the benchside (pharmacology and physiology) can be used at the patient's bedside. The social work intern can support the patient's feelings, fears, and confusion about their injuries, always remembering to refer the patient back to the nurse or other members of the medical team when their questions are not within a social worker's wheelhouse.

Interns who are placed on a burn unit will learn from physicians and nurses that burns are problematic in part because the skin is the largest bodily organ and covers the entire surface area of the body, as well as parts of the gustatory (nasal cavities, mouth), respiratory (throat), reproductive (genitalia), auditory (auricle, ear canal), and visual (eyelid) systems (Campbell, 2011). Both the physical and emotional trauma for the patient depend upon the extent of their injury. Subsequently, the intern's experience will depend upon the degree of the patient's damage: to be considered are breadth, depth, and location.

Breadth

One way clinicians assess the severity of burns is by applying Wallace's (1951) Rule of Nines to quantify their size. This is done by visualizing the surface area of the burn in relation to the body, known as the total body surface area (TBSA) of the burn. To do so, the body is mentally divided into smaller areas that are each approximately nine percent of the full body area: The head and neck; each upper limb; each lower limb's front (anterior) side; each lower limb's back (posterior) side; and the torso, comprising chest (anterior top), stomach (anterior bottom), upper back (posterior top), and lower back and buttocks (posterior bottom; Wallace, 1951). The last and ninth area covers one percent, represented by the genital region (Colbert et al., 2020). Generally, the size of an adult palm represents approximately one percent of the total body surface area. Jeschke and colleagues (2015) reported that among adults, a TBSA greater than 42 percent was correlated with infection and greater than 44 percent with mortality.

Depth

Skin is composed of three layers: the epidermis, dermis, and hypodermis. The outer, top layer of skin, the epidermis, is responsible for protecting the body from the environment and is the body's first layer of defense (Singh & Archana, 2008). When this layer is burned, bacteria can enter and infect the body (Singh & Archana, 2008). The middle layer, the dermis, lies below the epidermis and above the bottom layer, the hypodermis (Singh & Archana, 2008). When the burn extends to the middle (dermis) but the lowest (hypodermis) level is healthy, this interferes with support to the skin's top layer and prevention of excessive water loss (Lai-Cheong & McGrath, 2021). When the healthy bottom layer is damaged, tissues deep within the body that nourish the

epidermis with nutrients and provide insulation and temperature regulation lose protection (Colbert et al., 2020). Clearly a burn to any layer of the skin can interfere with a number of vital functions that skin performs.

Medical treatment of burns involves avoiding infections (Souto et al., 2020), which can range from bacteria (e.g., E. coli, staphylococcus, MRSA) to viruses (e.g., Herpes simplex, Varicella-zoster) to fungi (e.g., Candida, Aspergillus), and repairing the integrity of the skin. Several techniques have been used for wound repair, including application of grafts to the affected areas (Shpichka et al., 2019). There are several common sources of material for grafts. Human fetal cells, as well as human cadaver or animal skin, are the primary technological techniques that are used to treat burns (Shpichka et al., 2019).

The depth of burns, and their psychological effect on the intern, can mirror the physical effect on the patient. According to Colbert and colleagues (2020), first degree burns damage the first layer of the epidermis, which becomes painful and turns red, but does not blister. The burned skin peels but does not result in scarring. Many people have experienced these burns from being in the sun without protection, thus the effect on the intern is minimal. Second degree burns damage the first as well as the second layers of epidermis and typically cause a blister, the size of which and the time it takes for the skin to recover depends upon the depth of the burn. Recovery from second degree burns that involve only the epidermis can take up to 14 days to heal, while second degree burns that extend deep into the dermis can take up to 14 weeks to heal and typically involve scarring and the potential for infection (Warby & Maani, 2019). Full thickness burns include third and fourth degree burns and extend down into the entirety of the skin, often to the bone. These burns are so deep that the pain receptors are destroyed. The skin can turn waxy and white, dark brown, or black and result in scarring. Third degree burns are susceptible to infection and can result in death. Fourth degree burns damage all layers of the skin. The skin becomes charred, and changes colors as it does with third degree burns. These burns damage the structure of the skin by killing the pain receptors, hair follicles, and sweat glands. They can extend down to the muscle, tendons and bone and are life-threatening. While victims of fourth degree burns do not feel pain, they are at high risk of infection that often results in amputations and death (Colbert et al., 2020). The patients' faces and bodies may have been distorted by fire and attempts to treat the burns with grafts. Interns may have difficulty managing their reactions to seeing the physical symptoms of the patients; many have required debriefing from their supervisor and/or field practicum professor.

A medical social work intern plays an essential role in supporting burn patients, and the intensity of this role often parallels the severity of the burns observed. With first degree burns, where injuries are mild and visually non-distressing, the intern typically provides basic psychoeducation, reassurance, and simple minimal emotional impact. For second degree burns, which involve blistering, significant pain, and potential scarring, the intern becomes more involved in helping patients manage anxiety, cope with body-image concerns, and adhere to wound care while also supporting family members; this stage may also heighten the intern's emotional response and require increased supervisory guidance. With third and fourth degree burns, where patients may experience disfigurement, risk of infection, amputations, or life-

threatening complications, the intern's role expands to a trauma-informed care approach, crisis intervention, psychosocial assessment, family meetings, and long-term planning. These severe cases can evoke strong emotional reactions in interns; therefore, supervisors should provide debriefing and encourage self-care, which are crucial for managing secondary trauma.

Location

In addition to the TBSA that is affected, burn severity may also be correlated to location. In situations where the service personnel are injured by roadside bombs that ignite gasoline in their tanks or Humvees, they can be injured over extensive parts of their body. In situations where they step on a landmine, the impact of the explosion travels up from the feet to the genitals and the torso. Burns that involve joints, the face, hands, or genitals are considered more severe (Jeschke et al., 2015). Burns to the genitourinary system can have long-lasting emotional effects alongside the physical complications because these burns often severely injure the patient's ability to procreate, which can be devastating to soldiers often in their prime childbearing years.

For all burn levels, the intern contributes to patient well-being while developing professional resilience and competencies in complex medical settings. Supervisors can guide this understanding and regularly facilitate debriefing to process and assist in the development of applicable knowledge and skills.

Traumatic Brain Injury (TBI)

Traumatic Brain Injury (TBI) is another of the signature injuries seen among military personnel (Hoge et al., 2008). Because today's conflicts are fought in unconventional ways where there are no distinct battle lines, each soldier is essentially at the frontline. The preferred weapon during modern wars has become the improvised explosive device (IED), which often injures rather than kills. Detonation of an IED can result in brain injuries when the brain is shaken within the skull upon direct impact, shrapnel from flying debris, or shock waves from the blast. Immediate assessment of brain function is the best way to prevent secondary brain injury, which can occur when the brain swells in response to the explosion (Zaman et al., 2024).

Social work intern students should learn and understand the impact of TBI, including the various tests and assessments. The intern will have to be able to communicate with the neurologist and nurse to understand the depth of the patient's injuries. Additionally, it is critical for the intern to comprehend the assessment and purpose to be able to effectively communicate with family and caregivers.

Two types of imaging tests are used to assess an individual's injury (Mayo Foundation for Medical Education & Research, 2020). The first is a Computerized Tomography (CT) scan, which uses X-rays that create views of damaged bone, swollen tissue, blood clots, and hemorrhages. According to Lee and Newberg (2005), after a TBI, repeated CT scans should be done to identify the location of potential hemorrhages. The second type of imaging is the functioning Magnetic Resonance Imaging (fMRI) test, which detects brain lesions that cannot be

identified with a CT scan (Lee & Newberg, 2005). Because of the level of detail in these fMRI-derived images, the physician can identify if there are individual brain lesions which are treatable (Lee & Newberg, 2005). This is important because the patient may need supplemental oxygen to allow energy that would be used to breathe to instead be used to fuel recovery. Due to the nature of TBI, anoxia or hypoxia to the brain could cause further injury.

In fact, the immediate objective after receiving a TBI is to limit swelling by increasing the level of oxygen to the tissues (Lin et al., 2008). One way to increase the amount of oxygen is by using hyperbaric oxygen treatment, which involves administering 100 percent oxygen through a facial mask while the patient is in a compression chamber (Lin et al., 2008). Reducing brain temperature is another treatment to alleviate swelling after a TBI (Sinclair & Andrews, 2010). Hypothermia can be achieved by cooling the external temperature of the body or the core bodily temperature. Andresen and colleagues (2015) reported that the target temperature should be between 89.6 to 93.2 degrees F (or 32 to 34 degrees C) for more than 48 hours.

While Haselsberger and colleagues (1988) suggest CT scans are preferable to MRIs after severe head trauma to assess bleeding outside the brain tissue, particularly if there is a possibility of postoperative complications. Additionally, CT scans are preferable when assessing TBI because there may be undetected metal shrapnel in the head (Lee & Newberg, 2005).

Because different brain areas are related to different functions, damage to different structures is related to deficits of those functions (Zaman et al., 2024). For example, because of the association of emotions in the limbic system, damage can disrupt production of hormones related to attachment (oxytocin) and interfere with their release (Colbert et al., 2020). This may have a profound effect on the patient's family members, as they are often yearning to reconnect with their loved one.

While trauma may injure only a specific location of the brain, it can also have global effects that affect the overall person (Teasdale & Jennett, 1974). Interestingly, lesions to both hemispheres (bilateral) of the prefrontal cortex can result in profound changes to one's overall personality and a loss of executive functions, such as reason and insight (Pirau & Lui, 2020). On the other hand, a lesion in only one hemisphere does not usually cause major changes to the personality (Hillis, 2014).

A social work student intern working in a TBI unit will need to be aware of the potential lack of response from patients. Especially if inexperienced with TBI, students may find themselves frustrated with symptoms that impact the sociability of patients, such as flat affect and apathy. Students facing little to no feedback, reaction, or perceived appreciation for their effort may struggle to feel confident in their work and will need support from their field supervisor to help process feelings of demoralization and insecurity. The field supervisor must ensure students are well-versed about TBI, particularly how patients' emotional responses may be dulled, to best mitigate this issue.

Relatedly, when an intern is working with a client affected by TBI, their primary client may then

instead become the client's family members, who are similarly struggling as new caregivers—with the added difficulty of having prior familiarity with the patient. The student can apply professional use of self (Walters, 2008) to help the family in processing their frustration that they are no longer receiving emotional support from the patient. Kratz and colleagues (2017) conducted a study on the family members of patients who sustained moderate or severe TBI and found that they were overburdened with responsibilities; grieved the loss of the person; felt anger, guilt, anxiety, and/or sadness; and felt their lives were interrupted or lost.

Working with the family, who may be managing the patient's low responsiveness and heightened emotional outbursts, grieving the loss of the patient's pre-TBI function, and/or simply struggling to meet the patient's new need for around-the-clock support will be challenging. The social work intern may need to connect families to support groups or outside resources for additional help. Encouraging appropriate self-care for caregivers is equally important to help bolster their success and avoid caregiver burnout. Student interns can ensure caregivers receive the critical support they require to continue to provide effective aid to the patient. As discharge approaches, social work practitioners may also need to provide assistance in this decision-making.

Koehmstedt and colleagues (2018) reported TBI patients can experience increased well-being from several factors, namely being provided a more personalized medical plan, an advocate or "point person" designated to help the family, and guidance in adjusting to the chronic nature of TBI aftereffects. Social workers can ensure these are given by coordinating health and social services, providing the family with more information about the patient's specific injury, and discussing medical information in less technical language. Social workers can also coordinate community support and professional in-home help which, according to Koehmstedt and colleagues (2018), eases the strain on caregivers.

Social Work Training

How do social work schools train MSW students to provide the tools necessary to provide care to military patients with burns and TBIs and their families? In the academic setting, student interns typically receive a total of 63 credit hours of academic courses in order to graduate, which is beyond the typical 60 credit requirement due to their specialization (Norfolk State University, n.d.). During the second year of the specialization curriculum, the total number of field practicum hours providing instruction in a comprehensive military specialization is often 546 hours from MSW-trained field instructors (Council on Social Work Education [CSWE], n.d.). The level of training for the field practicum faculty includes MSW and PhDs from an accredited CSWE university. The field practicum faculty at our school, the Ethelyn R Strong School of Social Work, have well over 20 years' experience as licensed social workers or licensed clinical social workers in clinical or military sectors. Their experience has consistently provided an elevated quality of supervision. The field practicum faculty often meet with students at least two hours weekly to discuss concerns and provide support. Students are also required to attend a two-hour field seminar class each week.

According to informal data from the MSW students at their placement at a Veterans Medical Center Hospital, reports indicate students were satisfied or highly satisfied with the quality of their placement and supervision. This finding supports Cleak and colleagues' (2022) report that Master-level students' satisfaction with their placement is in large part related to the quality of supervision. Each CSWE-accredited social work school requires that every student receive a total of 900 supervised hours from a clinician for two years after earning their MSW. Satisfaction varies based on the competence and support of the instructor. A key factor in the field experience of African American students, for example, is their relationship with and perceived support from their assigned agency (Mehrotra & Gooding, 2022). These findings support the positive experiences detailed by MSW students placed at a Veterans Medical Center Hospital. Every student placed at the VA after receiving two semesters of supervision chose to apply for employment at the facility.

The students were highly satisfied their coursework prepared them to work successfully at any Veterans Medical Center Hospital as MSW social workers. Specifically, their weekly supervision and the support given in their field seminar class reinforced their learning objectives. The students' positive report of their field experience included their high level of satisfaction with the various capacities afforded to a Master-level social work clinician. Based on a CSWE curriculum, if a social work student prepares to work in the medical social work field with military patients, they can potentially receive their advanced electives in military-centered courses (e.g., social work practice with military families, effects of trauma on military personnel, medical treatment of military clients). Ideally, their field instruction will take place in military settings, thus providing them with a well-rounded intensive social work experience. If the students do not have access to a Veterans Medical Center Hospital in the community, because of the frequency of traumatic brain injuries and burns among the general population, they can still potentially work with non-military clients in general hospitals. Additionally, it has been found training in skill development assists students to alleviate burnout in hospital settings (Cohen & Gagin, 2005). It was further suggested within student feedback that understanding STEM-H terminology provides interns the ability to comprehend the condition of the patient, then translate that information to the family when meeting with them at the patient's bedside.

This article uses a compilation of experiences of Master-level students who are specializing in work with military personnel. Student Intern #1, whom we refer to as "Michelle," is working with patients in the burn unit, and Student Intern #2, whom we refer to as "Dwight," is working with patients in the TBI unit. These student simulations/replications put the spotlight on experiences student interns may encounter when working with military patients who have sustained signature injuries.

Michelle

"Michelle" is a 22-year-old student who is interested in working with military veterans who have experienced bodily trauma from IED-related injuries. Although she has not served in the military, her brother served in the Army until he was injured in Afghanistan from a roadside bomb. He was treated for burns and released to his parents' home for long-term care, where

Michelle gained personal experience caregiving. Michelle asked to be placed in the burn unit at the local VA and is now struggling with the patients' experience of pain. According to Patterson and colleagues (2004), burns that require hospitalization often cause severe pain and are the most difficult to treat compared to other sources of acute pain. Michelle wasn't prepared for the several origins of her patients' severe pain: background pain from the burn itself; pain from tissue damage; pain from procedures and treatment, including wound-cleaning, debridement (scraping off dead tissue to create a clean wound bed), harvesting and applying grafts, and changing gauze and staples; breakthrough pain that occurs when the analgesics are inadequate (Patterson et al., 2004); and pain of post-surgical procedures prescribed to repair wounds and scars (Griggs et al., 2017). Michelle needed to work with her supervisor to process her feelings about her brother's injuries upon seeing her burn patients struggle with the pain experienced from the treatments. Michelle's supervisor was able to help her differentiate her personal self and rely on her professional use of self when interacting with patients and their families.

Michelle is learning that there are several medications often prescribed for reduction of pain, including drugs in the opioid family, which can be addictive. Because pain can be long-lasting, chronic administration of opioids results in physiological tolerance. Achieving a balance between the doses needed to alleviate the patients' pain while protecting them from becoming addicted or overdosing is often difficult, and in field seminar, Michelle wrestled with her concerns that it was unethical for the doctors to cause an iatrogenic addiction in the patient. Her field instructor and classroom discussion helped Michelle come to terms with the reality that patients do sometimes become addicted as the result of their treatment, but it is the responsibility of the medical staff to help the patient withdraw safely from the opioid before they are discharged from the hospital. For example, intravenous pain medication is often required early in burn treatment, but patients prefer to be switched to oral pain medication before they are discharged home (Patterson et al., 2004).

Michelle was also not emotionally prepared for some of the patients developing anxiety and even PTSD in response to the painful medical procedures. Patients' experiences of anxiety are related to increases in their perception of pain, which results in an increased need for medication. She was grateful that the patients' anxiety was controlled by the prescribed benzodiazepines they received before the procedures (Patterson et al., 2004). According to Griggs and colleagues (2017), minor tranquilizers or anti-anxiety medication, especially benzodiazepines, are used to reduce anxiety about upcoming painful procedures and have been shown to help patients tolerate treatments. Surprisingly, they also found that antipsychotic medication has been successful in reducing procedural pain, especially in the case of anxiety (Griggs et al., 2017).

Result

Receiving field practicum instruction as a student intern placed on a burn unit at a Veterans Medical Center Hospital can be challenging because of the emotional and physical trauma the patients suffer. Michelle needs to process her feelings around her patients' experiences of pain and their family's suffering. Michelle needed much emotional support to be able to use her self

in a professional manner because of the similarities between her brother's injuries and her patients'. Having learned STEM-H terminology and concepts made it possible for Michelle to learn basic tenants of pharmacology and physiology with which to understand analgesic medication. She was able to voice her concerns about patients' iatrogenic addiction from prolonged opioid use and learn how the medical team helps patients withdraw from dependency on medications needed for pain.

Dwight

Dwight is a 25-year-old, second-year, Caucasian MSW student who was working as a psychiatric technician at a free-standing psychiatric hospital for several years after he earned his BA in psychology. Working with veterans with PTSD was less interesting to him than working with veterans with brain damage. While working as a technician in the psychiatric hospital, he became familiar with young adults who had developed TBIs as the result of automobile accidents, and he decided he wanted to work with similar patients after earning his MSW. He did not personally know someone with profound TBI, but he did know several people who had suffered mild TBI (concussions).

Dwight was inexperienced in working with individuals from other cultures, and thus multicultural competency was addressed in supervision. One of the scenarios he and his supervisor discussed was the prevalence of TBI from violence in the community. His fellow field practicum student, an African American female, shared information about the danger in her community due to overpolicing. Dwight explored anecdotal evidence with her and developed cultural competency from the conversation he shared in field practicum class. He remembered Competency #1 (CSWE, 2022), which mandates he protect people's confidentiality, and did not give identifying information.

Dwight should be aware of the various challenges related to working with African American military personnel (Wong et al., 2020). Dwight needs to develop his cultural competency. His supervisor needs to have training surrounding cultural competency and the unique situations experienced by military personnel. This is an important factor, as the military has a diverse population that requires its employees to have a vast knowledge of various cultures. One particular theoretical framework that would assist when working with people of color is the Afrocentric Paradigm (Schiele, 2017), which focuses on cultural values of African patients and on eliminating oppression and spiritual alienation. This paradigm could assist Dwight in developing his professional competence as well as expanding his knowledge and skill base because its focus is the cultural values of people of African descent (Schiele, 2002).

Mendez et al. (2013) compared military patients' personalities who had experienced blast-force versus blunt-force trauma. He found those patients with blunt-force trauma were more likely to experience higher rates of aloofness, negativist involvement, and apathy (Mendez et al., 2013). When the patients in the blast-force trauma group were studied, they experienced more anger, frustration, and affective-anxiety lability. The concept of benchside to bedside care was applicable in this component of his field practicum placement. Dwight discussed this approach

in team meetings to verify his understanding of the STEM information and how he would apply it to health.

One of Dwight's patients, "Kevin," exhibits injuries ranging from moderate to extreme levels of trauma. Dwight is susceptible to depression and must engage in self-care when he works with difficult cases. One aspect of self-care was for him to process his feelings with his supervisor and explore questions about his patients' success rate after treatment. One of Dwight's concerns was the inability to explain the context of the patient's injuries to family members. The patient's injuries happened as he and his fellow soldiers were in a convoy of tanks driving down the street; the tank in front of him ran over a landmine. Kevin was propelled up off the seat and hit his head against the roof of the tank. This action caused his brain to receive blunt force trauma (from striking the roof) as well as blast force trauma (from being thrown by the mine explosion). Like most of the soldiers in Iraq and Afghanistan, Kevin was young and just beginning to develop his life. Experiencing a traumatic injury can affect a young soldier's life trajectory, which includes their ability to earn a living, start a family, and maintain emotional relationships with their families and friends. Because Dwight is the same age as Kevin and many of the other soldiers who suffer TBI, he may need help separating himself from clients to use his self in a professional manner.

Result

Dwight's reaction to his internship is compounded because he is similar in age to many of the patients he will work with. Some of his patients' TBIs were received from exposure to blasts, but others were the result of automobile accidents, which is a frequent outcome that affects many individuals, including civilians. Thus, he will need to practice self-care to prevent himself from becoming overwhelmed not only by interacting with clients who have faced devastating trauma, but also the potential familiarity of how that trauma affects their lives. Learning STEM-H vocabulary is necessary for him to understand the hospital team members and not exist in a vacuum-like environment at his placement. His supervisor in his field practicum site may work with him during his assignment to help him process his reactions so he is not isolated. In addition to working with his patients, Dwight worked with families who were struggling with grief and loss of their child because their personality was profoundly altered.

Conclusion

This article introduces two fictive students who are obtaining their field experience at a Veterans Medical Center Hospital in either the burn unit or the TBI unit to consider the emotional challenges interns weather in the face of extreme physical trauma and how faculty supervisors can provide support.

In treating burns, a student may experience secondary trauma from the patient's reaction to the debridement of burned tissue or from the patient's opioid treatment for pain. The field supervision will need to be able to inform the student how to treat pain with addictive drugs. In treating TBIs, a student may struggle to process their reactions to treating young people who

have become paralyzed or experienced personality changes. The supervisor may need to support the field student working with family members who have developed caregiver burnout. To best assist students, supervision guiding questions would include those that explore students' preconceived notions about addiction to hospital-administered pain medications, as well as their emotional reactions to working with individuals with TBIs to provide reinforcement and guidance.

Future qualitative research is needed to examine each student who interns on burn units and TBI units to explore their reactions to their placement and supervision.

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